DIAGNOSTIC SERVICES FOR MALADJUSTED FOSTER CHILDREN: AN ORIENTATION TOWARD AN ACUTE NEED*

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THIS paper will describe, and attempt to evaluate, the function of a special psychiatric clinic established pro tempore to serve foster children in the care of city and county welfare departments within the State of Maryland. The data upon which this report is based were obtained from a systematic review of the first 48 cases referred; their social adjustments were determined 6 to 18 months after the original diagnostic studies. The degree of success apparent in the results to be presented suggested that the design of this consultation service is worthy of communication to other workers who are facing similar problems. On a broader level, it seemed to us to carry important implications for the orientation of orthopsychiatric workers to measures other than psychotherapy in the strict sense, which may be useful in helping maladjusted children to achieve social integration.

This study was undertaken in collaboration with the Social Service Division of the Department of Mental Hygiene of the State of Maryland.[1] We shall present the data and conclusions of this report according to the following outline: 1) mode of organization of the clinic, 2) characteristics of the population served, 3) treatment plans, 4) results observed in relation to recommendations made and carried out, 5) evaluation of clinic services by the referring agency, and 6) theoretical implications.

Organization of the Clinic

Just as the shortage of psychiatric facilities in the community had necessitated the creation of this special unit, the limitation in available personnel dictated an effort at their most efficient utilization. The plan for this service grew out of (a) a pilot outpatient study at the Springfield State Hospital, (b) the experience of the preadmission staff of the Rosewood State Training School, and (c) the experience of the psychiatric consultant in community mental hygiene clinics. The clinic was designed with the further purpose of

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providing data that would prove useful in planning preadmission and intake procedures for the new Unit for Emotionally Disturbed Children[2] which was then in construction. It was decided to offer diagnostic evaluations and the therapeutic recommendations stemming therefrom, which were to be utilized by the welfare agency as best it could. Manifestly, an attempt to offer even short-term psychotherapy would have materially reduced the number of children who could have been seen in the one afternoon a week the clinic was in session. This appeared unjustified in view of our firm conviction that therapeutic measures potentially available within the casework services of the welfare agency, in the more efficient utilization of the special services of the public schools, and in the wider use of other community facilities could be of substantial benefit to disturbed children.

Clinic intake was limited by prior agreement to children who had been committed to the care of the welfare departments within the state and who presented, in the estimation of the caseworker and her supervisor, a problem requiring psychiatric guidance. No control over intake was exercised by the clinic except for that which resulted from the enhanced judgment of agency workers and clinic members as a result of their participation in joint discussion of prior cases. Clinic procedure was based on rather orthodox orthopsychiatric design. Diagnostic studies began with a complete report submitted by the child's worker, based upon material within agency files. This history was supplemented by the clinic social worker, who interviewed the agency worker, foster parents and real parents where available. This procedure might appear redundant, but the purposes for which information is assembled by a welfare agency are not necessarily those of a psychiatric clinic. Consequently, agency records were at times deficient in the data we desired. Moreover, on a significant number of occasions, foster parents or real parents presented a different account to the clinic than they had to the agency, both with regard to the child's behavior and to their own feelings about the child. We felt, in addition, that the foster parents often derived status from participation in the study of the children and thereafter exerted greater effort on their behalf.

Study of the child himself began with a psychological survey that included psychometric and projective tests plus achievement tests whenever possible. Each child was then seen for a single clinical interview by the psychiatric consultant. Findings were presented in the customary manner by each member of the clinic group at a staff conference in which the worker and supervisor from the referring agency were intended to be active participants. Diagnostic formulations and therapeutic recommendations were arrived at by thorough discussion, with final responsibility resting with the psychiatrist as

[2] This Unit has now been officially designated as the Esther Loring Richards Childrens Center, Owing Mills, Maryland.

a physician. Follow-up contacts with the child were maintained through the agency by the clinic social worker.

Characteristics of the Population Served

Of the total group of 48 children, 37 were boys and 11 girls. This sex ratio is in keeping with the expectation for aggressive behavior disorders, which were the predominant problems presented. The ratio of Negro to white children was approximately 1 to 1.5, slightly lower than the population distribution for the agency, but not significantly different from it. The age range of the children was from 4 years (one child) to 16 years (one child). Half the children were between 8 and 12 years, and the median age was 11.

All of the children were in the custody of a department of welfare; all but one were in foster care. An attempt was made to ascertain the number of placements each child had undergone (Table 1). The figures that emerged

TABLE 1. NUMBER OF PLACEMENTS PER CHILD

Number of Placements	*Number of Children*
0	1
1	12
2	9
3	11
4	7
5	5
6	3
Total	48

probably understate matters, for the number of "placements" (temporary abandonments) arranged by the children's parents prior to the agency's intervention are likely to have been inaccurately reported.

Before concluding that the agencies had been zealously overplacing children, the reader should note that replacements had at times been necessitated by illness or death in the foster home, at others had been initiated on the insistence of foster parents that the child be removed because of unacceptable behavior, and still others had been determined by the agency when a previously well regarded foster home was discovered to be inadequate or even abusive. These children, let it be recognized, were difficult to place because of the very situation that brought them into commitment. The absence of adequate alternative plans for care led at times to inadvisable placement of children whose inability to accept the closeness of a family life could have been foreseen. In other instances, "temporary" placements which had lasted a year or longer, and had resulted in a satisfactory adjustment, were interrupted for transfer to a "permanent" home to which the child then might

not adjust. Some of the multiple placements reflected the unpredictable vicissitudes of social reality; others stemmed from inadequate planning or insufficient knowledge of the foster home. With the present understaffing of municipal welfare departments, the large number of untrained workers, and the high turnover rate among workers in consequence of inadequate welfare budgets, it would appear that such experiences, though in part preventable with present knowledge, are likely to continue to occur.

The homes from which most of these children had come prior to commitment were uniformly bad. Gross neglect, physical abuse, sexual assaults, frequent desertions, violent marital discord, were recurrent themes. One girl had been forced into prostitution by her mother; a boy had an internal organ ruptured when his father beat him; a third child saw his father murder his mother's paramour. These children lived in slum areas, whose social anomie contributed further to their psychological disintegration and accelerated their gravitation toward socially unacceptable behavior patterns. Many of the life histories beggar description with children abandoned and neglected, scavenging through alleys, too terrified to respond to human warmth on the rare occasions when it was available. When we consider that 26 of these children were then to undergo three more foster placements, and 14 four or more, we will have some conception of the instability that characterized their lives and of how little reason they had to put any trust in the permanence of human relationships.

Since the clinic facility was known to be limited in the number of consultations it could provide, and had to be shared by several agencies, the children referred had been selected from the most pressing problems the agencies faced. In most cases, a crisis of direction had arisen: impending court action, school expulsion, requests by foster parents for removal from the home, a suicidal or homicidal gesture, and so on. A simple listing of the major complaints will give an idea of the range and severity of problems represented (Table 2). The number of symptoms of disturbances exceeds the number of children by a factor of three, since each case exhibited multiple difficulties; "minor" signs of psychologic malfunction (enuresis, feeding problems, etc.) have not been included.

Assessment of the intellectual status of these children was a particularly difficult task. The maladaptive behavior that provided the reason for referral frequently complicated the interpersonal equation in the testing situation. Most of these children had grown up in culturally impoverished environments, where motivation for academic performance and exposure to learning were severely restricted. Schooling had been indifferent, with frequent changes of school and a predominantly negativistic attitude toward learning; this was reflected in marked discrepancies between chronological age and school achievement level. The psychometric scores on the Wechsler Intelligence Scale for Children (WISC) were usually interpreted by the psy-

TABLE 2. PRESENTING PROBLEMS

Type of Problem	*Number of Children*
Aggressive behavior	30
Stealing	30
Major school maladjustment	26
Repeated runaways	11
Deviant sex behavior	9
Fire-setting	8
Neurotic patterns (hysteria, obsessive-compulsive, etc.)	8
Uncontrollable rage reactions	7
Severe speech problems	6
Suicidal attempts	5
Encopresis	4
Psychosis	2

chologist as underestimating native capacity. Test results reported in Table 3 will, however, serve to indicate that serious intellectual limitation was not a major factor in the great majority of cases; this is the more forcibly true if we recall the environmental and emotional factors that operated to depress the obtained scores.

We might summarize the pertinent characteristics of the patients referred in the following terms: 3 out of 4 were boys; half were in the age range from 8 to 12; all had been committed to the custody of a welfare department. They stemmed from homes in which both physical and emotional neglect had been prominent and from neighborhoods on the lowest economic fringe of the community. Half had undergone three or more foster placements after leaving home. The behavior which brought them to psychiatric attention was predominantly aggressive and antisocial in character. Two thirds had IQ's in the 70–89 range, which probably underestimated their potential

TABLE 3. PSYCHOMETRIC LEVELS

WISC IQ's	*Number of Children*
55–59	2
60–69	3
70–79	15
80–89	17
90–99	9
100–104	2
Total	48

ability. Almost all were one or more grades below expectation in academic achievement, though not necessarily in school placement.

Treatment Plans

Planning for each child began with a diagnostic appraisal oriented toward an estimation of the type and severity of the problem, both to the patient and to the community; the dynamics of the disturbed behavior; and the likelihood of response to treatment measures. The discussion of possible therapeutic plans was guided by considerations of their suitability for the patient and their availability in his locality. Programs were formulated with the recognition that what was theoretically available might not actually be obtainable in a given instance; alternative courses were set out in order of preference. Where we felt that there was little probability that the kind of treatment the community was able to provide would be of benefit to the patient, we stated so unequivocally. While not usually considered a therapeutic measure in itself, the diagnostic formulation at the case conference was actually the foundation of all subsequent treatment. It helped to clarify and to bring together the thinking of all those who were participating in planning for the child. It provided the guidelines for a rational approach to the resolution of his difficulties. It often resulted in the conservation of a considerable amount of social energy previously expended on a retrogressing disorder that could not possibly be resolved in the fashion in which it was being approached.

In view of the traumatic effect of the many moves these children had already experienced, we were disposed to approach the question of removal from a home much as if the foster home were the child's own. Replacement was recommended only in the presence of compelling indications. But 12 of the 48 children were considered as unlikely to profit from foster care of any kind; 3 of these were referred to a state hospital, 3 to the training school for delinquents, 3 to a residential treatment center and 3 to a children's home. In 2 additional cases, the children were avidly seeking identification with a healthy part of their own family, and plans were developed for their return to relatives. There remained 34 children for whom foster care was deemed the most suitable living arrangement. In 25 (73%) of these cases, we urged retention in the current home (with the provision of intensive casework services to foster parents in 19 cases). In 4 instances, the foster home was considered so unsatisfactory that we were willing to hazard a move into another home, the ideal characteristics of which were stipulated as well as possible. In the remaining 5, the children were regarded as so disturbed, though still capable of responding to foster care, that we felt highly selected and thoroughly developed foster homes were required. These cases were referred to the specialized foster care program of the Family and Children's Society of Baltimore. We might comment parenthetically on the excellent quality of

this service which resulted in notable progress in the children under its care. See Table 4.

Where retention in the home was recommended, a good deal of casework on the part of the agency was necessitated. In some of these instances, the foster parents had requested removal because of the child's disturbing behavior; in others, the foster parents, just as own parents may, exhibited characteristics that were part of the children's problems. But where malleability in attitudes appeared to exist, an attempt was made to outline a program for altering them. Frequently, the foster parents were so encouraged by the very fact that psychiatric guidance was being provided that they

TABLE 4. THERAPEUTIC LIVING ARRANGEMENTS

Foster care appropriate		
Retain in current home	25	
Move to new DPW home	4	
Specialized foster care	5	
Total		34
Own family available	2	2
Foster care unsuitable		
Children's home	3	
Residential treatment center	3	
State hospital	3	
Training school	3	
Total		12
Total number of cases		48

thenceforth approached their ward's difficulties with renewed optimism. Where possible, we complimented them for the efforts they had put forth, recognizing frankly that they had inherited children who were difficult to rehabilitate. We tried to anticipate the problems that might arise and the dynamics behind them, in order that the worker could discuss these in advance with the foster mother. An important aspect of the new *rapprochement* between child and foster parents often resided in casework with the child to help him more fully to understand why he had been removed from his own home and how his own behavior was creating some of the attitudes he resented.

The list of therapeutic measures employed for the children who were retained in the community surely must begin with the case services of the welfare agencies. Often, the caseworker had intuitively formulated the very approach we were able to design but, lacking theoretical clarity, doubted her

own judgment. The simple reaffirmation provided by the clinic conference enabled her to pursue her own course with renewed confidence. A major problem for the worker was the onus of bearing responsibility for decisions in an area in which she lacked medical competence; once the clinic took that responsibility, she could proceed with the sense of being part of a therapeutic team. Related to this difficulty was a certain devaluation of casework as opposed to a glorified conception of "psychotherapy." When goals and purposes could be outlined, when she no longer had to function as a doctor, she could utilize her own skills for the benefit of child and family. On the other hand, in the instances where foster care was being provided a child who could not possibly profit from it, the relief experienced by recognition of this fact and the absolution provided for her own guilt stemming from frustration enabled her to discriminate between situations. This was reflected in increasingly more suitable referrals as the clinic's operation continued.

Second in importance to agency casework services was the reassessment of the patients' school programs. Whatever meaning psychometric and achievement tests may have in terms of innate endowment, they are useful as predictors of academic performance. Children who were miserable misfits in regular classrooms often improved appreciably when transferred to ungraded classes, vocational schools, remedial reading classes, or special school programs. A few were upgraded and performed far better. One patient in particular felt terribly inferior and performed poorly in school. So encouraged was she by the clinical interview, in which the implications of her normal intelligence were discussed thoroughly with her and in which confident expectation was expressed in her future improvement, that she ceased to present any major problem from that day onward and is now a good student in her class. True, this was an exceptional experience, but it illustrates what occurred less emphatically in others.

Psychotherapy was recommended only in those cases in which it seemed particularly urgent and in which clear benefit was anticipated. In the majority of the cases, the consulting psychiatrist did not consider that the children would make use of such a service; it was his feeling that environmental manipulation was more likely to be fruitful with this group of relatively inarticulate and poorly motivated patients. In addition, we knew that it was unlikely to be obtained even when recommended. It was suggested in 13 of the cases but secured in only 4. This small number does not permit any judgment of its merits relative to the other measures employed.

Extensive use was made of group experiences for these children: scouts, little league, police boys' clubs, camps, etc. They were children who had a marked disability in peer relations; left to their own devices, they tended to seek out similarly rejected children, in whose company antisocial traits were all the more likely to emerge. We hoped that constructive play activities,

under adult supervision, would channel their energies more productively at the same time that they provided the opportunity for a relationship to parent and sibling surrogates. In a similar vein, provision of a Big Brother was advised (in 9 cases); but this often did not eventuate, at least as much because of agency reluctance as because of lack of such services. More effective was the suggestion that the patient's own family be involved in the treatment plan whenever positive aspects existed in their relationship to particular patients; in other cases we supported the agency in strongly interdicting visits that were felt to be disturbing to the children and that had no hope of leading to a productive outcome.

In 11 cases, drug therapy was recommended, mostly as a palliative in order to make the child more acceptable to those around him, particularly when he was moving into a new situation. The main indication for its use was hyperkinetic and aggressive behavior. In 8 cases, further medical studies were suggested in order to clarify symptoms presented by the patients; this proved to be somewhat unsatisfactory as the peripheral position of the clinic resulted in the agency's having to take the responsibility for follow-through, and often for interpretation of findings. In 4 cases speech therapy was advised as a key part of the plan for these children; in one the result has been and remains spectacular in terms of general improvement as the speech difficulty was resolved by an experienced and exceptionally skilled therapist, Mr. Philip Glasner.

Results Observed

When this study was undertaken, the clinic had been in operation for 18 months. We attempted to determine the subsequent course of each child who had been seen during the first 12 months. Thus, the available period of follow-up varied from a maximum of 18 to a minimum of 6 months, with the average at somewhat over one year. It would have been preferable to have had each patient re-examined by the original team. The time that would have been required made this impossible in view of our primary service responsibility. We had, therefore, to content ourselves with securing as complete a report as possible from the referring agency. While necessarily far less complete than a full study this had the advantage of 1) relating change to the behavioral issues which concerned the social agency at the time of original referral, and 2) giving us a somewhat unbiased appraisal by an agency worker who had no stake in the clinic. Patients were categorized as "improved" if definite evidence of progress in social adjustment was substantiated in the agency report; "unimproved" was the classification assigned if there had been no significant change or if the situation had deteriorated. "Improved" should not be taken to imply total elimination of difficulties; on the contrary, in most cases problems remained but some of the

most troublesome had been ameliorated, and there was over-all indication of forward movement. Since clinical judgment was perforce based on limited information, we did not feel justified in subdividing these categories.

Over-all, 27 (56%) of the total group of 48 severely maladjusted children could be considered as improved at an average of one year later. If we eliminate the 4 on whom adequate follow-up data were not obtained, 61 per cent (27 of 44) may be considered as improved. Of the 4 cases with outcome unknown, 3 had moved away from the referring agency; one could not be traced for technical reasons. The percentage improved seems gratifyingly large in view of the predominant pattern of antisocial behavior displayed. But, the data are even more impressive if evaluated in terms of initial prognosis and the degree to which therapeutic recommendations were followed.

In 6 of the cases, prognosis was regarded as so poor, and the hazard to the patient or to others so marked, that removal from the community was considered to be the only solution. Subsequent developments tended to justify these estimations—in one case with near disastrous consequences.

> Raymond, 15, was referred because of chronic truancy, repeated stealing, destructiveness, and frequent assaults on other children, particularly minority group members. Personal history was sordid: desertion by an alcoholic mother, inadequate care by a grandmother who kept him only so long as support was forthcoming, residence from 5 to 12 in an orphanage, then return to a brutal father, several brief commitments to the training school, one at the father's behest. Clinical examination led to the psychiatric opinion that "it seems to be only a matter of time and opportunity before someone is seriously hurt as a result of his impulsive aggression." Removal from the community was urgently recommended. For reasons inexplicable to us, he was placed by the court in a foster home where he organized other foster children in a raid on a pawn shop from which a gun was stolen, later to be used in shooting a Negro child. He is now in the state reformatory.

If we removed from further consideration these 6 cases and the 4 whose outcome was unknown, 38 remained. We then proceeded to measure outcome against the agency's follow-through on therapeutic recommendations. When the major steps suggested had been pursued vigorously, the case was classified as "recommendations followed," although not in every such case had each step proved possible of execution. See Table 5.

Of the 27 cases in which recommendations had been followed, 24 (88%) showed improvement; of the 11 in which they had not been carried through, 3 (27%) had improved. By the Chi-square test for statistical significance, this difference between groups has a probability of arising on the basis of pure chance less than 1 in 1000 times ($p < .001$). This, however, seems to us to overstate the significance of the difference. The raw data from which the figures were derived were not so precise, nor the dichotomy between the categories so sharp, as this statistical manipulation implies. One might even wonder whether some unwitting judgment as to prognosis by the caseworker might not have influenced the zeal with which treatment plans were

TABLE 5. OUTCOME AND TREATMENT

Treatment	*Outcome*			*Total*
	Improved		*Unimproved*	
Recommendations followed	24		3	27
Recommendations *not* followed	3		8	11
Total	27		11	38
Prognosis poor			6	6
Outcome unknown		4		4
Grand total	27	4	17	48

pursued. Nonetheless, it would appear that the follow-up study does yield confirmation for our original hypothesis: that a diagnostic study leading to a therapeutic plan would serve a useful purpose in guiding a welfare agency in the management of maladjusted foster children.

Evaluation by Referring Agencies

As part of the assessment of clinic function, the supervisors of the referring agencies were requested to give us a frank evaluation of the merits and deficiencies of the service. The general feeling communicated was one of warm endorsement. At the risk of appearing like the purveyors of a nostrum who advertise their product by testimonial letters, we might cite an extract from a letter composed jointly by six casework supervisors, to exemplify the tone of the responses:

> We were unanimous in agreeing that the service has been exceedingly helpful. Particular mention was made . . . of suggestions . . . concerning anticipated problems that a child may have in the foster home . . . in specific down-to-earth terms . . . very useful to the worker in working with foster parents. We have all been impressed by the degree of relatedness to foster care . . . . The recommendations for planning . . . have always been related to available community resources. This has not always been our experience in working with other clinics. Nothing can be more frustrating than to have a recommendation which is impossible to follow because the community does not offer the service. Your clinic has been useful to us in confirming our focus in thinking about a particular child. It has been especially useful in diagnosing those problems which require a specialized form of care other than the foster care service which we give. . . . Being part of the conference has been an exceedingly stimulating experience . . . provocative to our thinking about planning for children. . . . It has also reinforced for us our conviction of the importance of early diagnosis and referral. . . .

We blush to add more!

At the same time, a number of criticisms were offered. Some were technical: the inconvenience of clinic location, the growing lag between request for

consultation and the time of appointment, the undue delay in supplying written reports, etc. Others dealt with issues of substance that we have still not resolved to our complete satisfaction.

The major area of difficulty lay in the relationship between clinic and agency workers. There was serious question of the value of our recapitulating a process of history taking already laboriously attempted by the agency. Our procedure of seeing the foster and real parents was regarded by most as complicating an existing relationship with the agency worker, though some saw it as valuable in giving foster parents a sense of participation. Clinic conferences frequently did not include the agency worker as a full participant since her role had been preempted by the clinic worker. We might note that the problem of interagency communication was not limited to the clinic experience; in some of the instances where recommendations were not fully accepted, we detected a reluctance to turn to another outside agency for help. We do agree, however, that the major fault stemmed from our failure to define the respective roles of the clinic, referring agency and other resources, and our lack of sensitivity to the problems this created.

The agency workers found the psychological reports unsatisfactory. Their technical verbiage was frequently unintelligible and at times frightening; evaluations and recommendations were insufficiently oriented to the social realities of foster care. Statements about normal or bright "potential" intelligence were often misleading, since they were unaccompanied by equally forceful comments about the current level of functioning that had to provide the basis for immediate academic plans.

In summary, however, both the clinic and the agency personnel appear agreed on the value of the service offered, a conclusion substantiated by the statistical data on outcome in relation to treatment efforts.

Theoretical Implications

The follow-up data appear to provide evidence for a percentage of *symptomatic* improvement in these patients that is about equivalent to expectation from psychotherapy. If this is indeed so, then this program of care, based on orthopsychiatric diagnosis, directed casework and environmental therapy, has important implications for the therapeutic orientation of community clinics. With the nationwide shortage of mental health workers, any method that reduces the professional time expended per patient and thus enables more patients to be reached merits careful consideration. But, before we can justifiably extend our findings to any broad generalizations, certain limiting conditions must be examined.

The patients we studied were rather homogeneous in socioeconomic class and behavioral characteristics. They were without exception economically and culturally underprivileged. Aggressive and sociopathic personality dis-

orders were by far the predominant diagnostic categories. It is by now well established that social class is significantly correlated with patterns of illness, with responsiveness to treatment and even with the modes of treatment likely to be assigned to patients. Similarly, the effectiveness of any modality of treatment is likely to vary with the type of pathology in behavior that constitutes the clinical problem that faces the therapist. Hence, it is clear that, whatever merit our therapeutic approach may have for disturbed children from "social problem" families, it would be unwarranted to extrapolate to the care of children who differ culturally and behaviorally, without a careful study of the clinical results with each such group. However, children from lower socioeconomic strata do comprise a major segment of the patient load of mental hygiene clinics.

But, even with these restrictions, do our results constitute proof of the validity of this method for an appropriately defined patient population? It is clear that symptomatic improvement has been demonstrated, but the question may be raised as to whether underlying disturbances in these patients have persisted unchecked. A yearlong follow-up evaluation limited to the measurement of change in symptomatic behavior gives no decisive evidence on this issue. Indeed, even the application of the most complete personality inventories we now possess would have had little reliability for long-term prediction. Only repeated reassessment of the course of these patients over the course of time will permit a final answer.

We would argue, however, that the symptomatic improvement achieved with these patients is in itself no unimportant gain. The key problem that had confronted us was the acting out of socially unacceptable impulses, rather than the personal distress of neurotic traits. The observed diminution in such behavior implies a significant restructuring of personality dynamics: by the progressive internalization of social mores with the consequent acquisition of a self concept to which the previous acts had become ego-dystonic; by the development of an ability to inhibit immediate response and to defer present needs for future goals; all of which implies a greater degree of positive relatedness to peer and authority groups.

These suppositions remain merely inferential. Perhaps an even more important consideration is the consequence for the child himself of the decrease in socially prohibited behavior. Patterns of fighting, truancy, fire-setting and stereotyped oppositional behavior almost guarantee group rejection. This reactive rejection, although caused by his own behavior, is experienced as further evidence of the essential unfairness and basic lovelessness of the social world by a child already severely scarred by nonacceptance in his nuclear family. It helps to perpetuate a perseverative state of suspiciousness and hostility. Prepared to fight, the child inevitably provokes counteraggression and concludes from its occurrence that his defensive expectation was

correct. Diminution in socially disturbing behavior, however induced, opens an avenue for at least occasional experiences of acceptance by significant others and permits the operant conditioning of socially conforming behavior. Thus, in itself, it enhances the probability of occurrence of constructive patterns of behavior as the child's overweening search for acceptance is more frequently rewarded. Obviously, this predicated sequence of events presupposes that the reaction pattern is one that can be modified by new life experience. Essentially, it was this judgment that constituted the basis for the decision as to which patients needed to be institutionalized and which were likely to respond to an outpatient program.

The response of these patients to a therapeutic program that emphasizes *social therapy* parallels the results that have been achieved by the conscious employment of the mental hospital as a therapeutic community. In both instances, psychiatric treatment is conceived in a broad frame of reference, within which individual psychotherapy occupies a respected but limited position. The current social matrix of psychiatric practice has tended at times to focus the academic training of the psychiatrist and his co-workers too exclusively upon the process of individual psychotherapy. The consequent neglect of other valuable therapeutic tools is particularly regrettable in the face of the enormity of the problem of treating mental illness in our society. It is in the hope of recalling to attention what *can* be accomplished for appropriately selected patients by social therapy that this study has been presented.